To help the financially needy obtain high-quality health care that is affordable, promotes independence, and provides customer satisfaction.

MassHealth
Continuous Nursing Services
Training and Resource Guide

MassHealth

Responsibilities of Independent Nurse Providers

Become familiar with MassHealth, program, billing and rate regulations available at www.mass.gov/masshealth

Develop and maintain required documents for recordkeeping as outlined in Subchapter 4 of the provider manual. You may use the Request and Justification for Continuous Skilled Nursing Services document for your plan of care and physician orders.

Maintain the member's medical data

Use www.mass.gov/masshealth to keep up to date on changes and updates

Automated Solutions

MassHealth has many automated solutions available to providers:

Web: www.mass.gov/masshealth

Electronic claim related solutions:

- Billing
- Provider Claims Submission Software (PCSS)

Electronic transactions via the Recipient Eligibility Verification System (REVS)

Electronic Funds Transfer (EFT)

Automated Prior Authorization System (APAS) for prior authorization requests www.masshealth-apas.com

mass.gov/masshealth

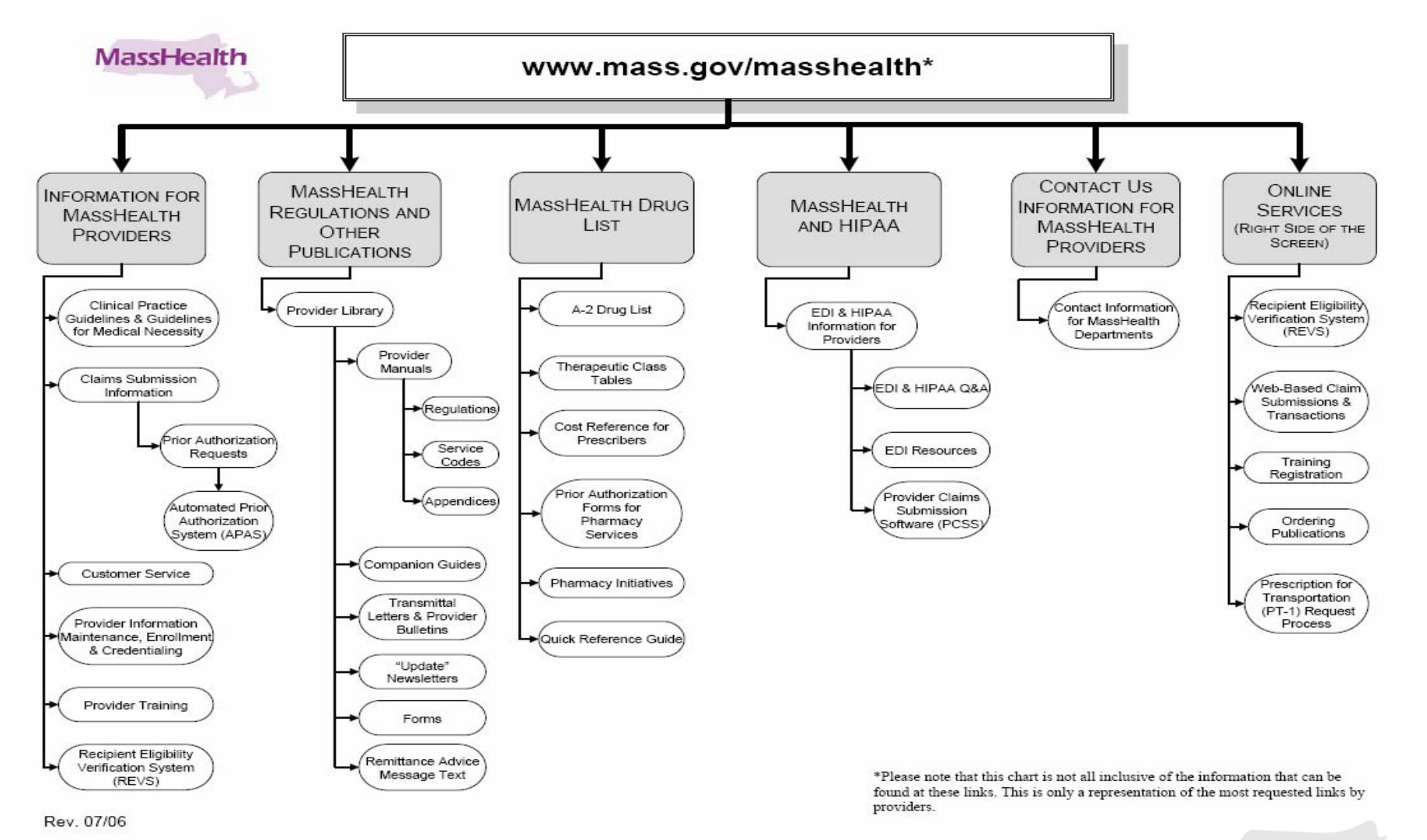
Access the information you need when you need it using the self-service options now available on the Web.

Some of the online services include:

- Eligibility Verification through REVS,
- Claim Submission (HIPAA 837),
- Electronic Remittance Advice (HIPAA 835),
- Claim Status Inquiry Capability,
- Provider Library (includes access to provider publications, bulletins, transmittal letters and provider manuals),
- Billing Tips,
- Provider Library email notifications and Preferred Method of Communications

Refer to www.mass.gov/masshealth handout

mass.gov/masshealth



Electronic Billing - PCSS

Provider Claim Submission Software (PCSS) was created to give MassHealth providers access to electronic transactions to allow MassHealth and providers to move toward standardization and electronic billing.

Software is **free of charge** and can be easily downloaded from: www.mass.gov/masshealth/pcss or may be sent on a CD.

There is a separate presentation to review PCSS and how to submit your claims using the software. Please refer to the Training page on the Web.

REVS

The Recipient Eligibility Verification System (REVS) has two automated solutions:

- WebREVS located at https://www.massrevs.eds.com
- REVS PC – for information call the REVS Help Desk at 1-800-462-7738

What is REVS?

- A computer information system that enables MassHealth providers to make claim-status inquiries and verify member eligibility
- The system is available 24 hours a day, seven days a week
- REVS offers easy access to the most current and complete member eligibility information
- REVS also enables providers to inquire about the status of adjudicated MassHealth claims

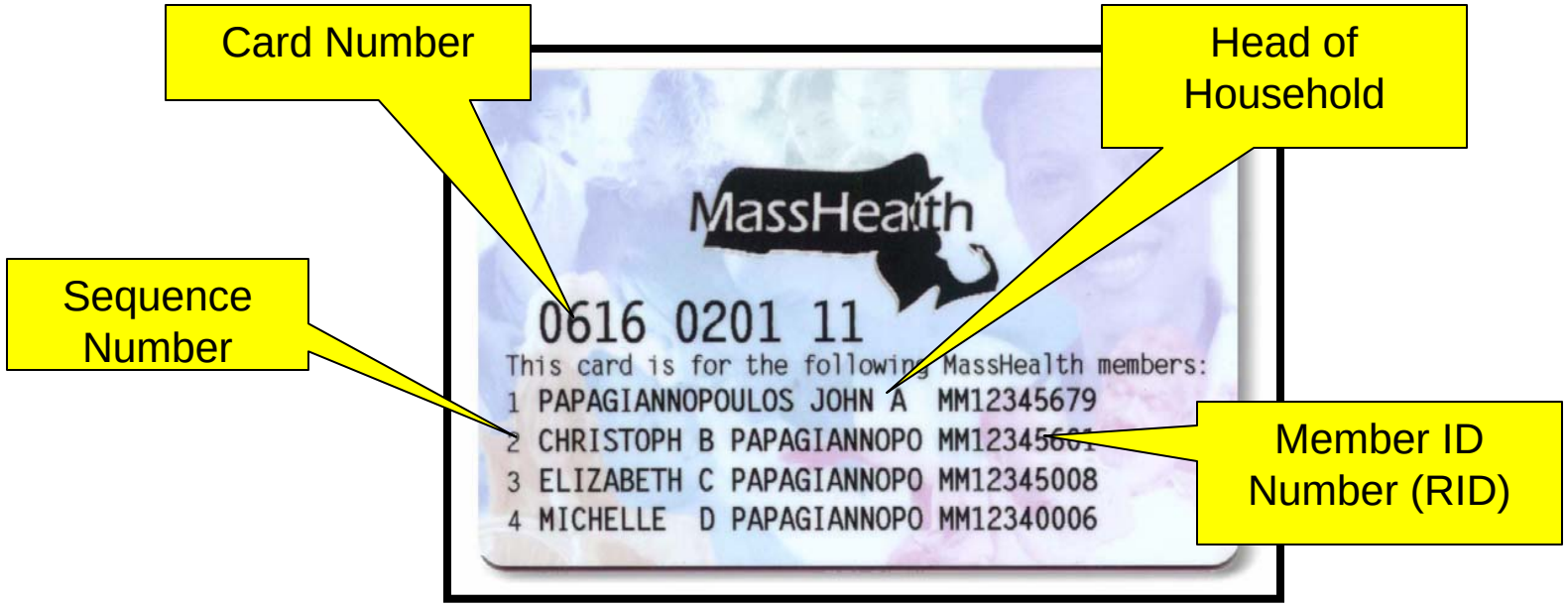
MassHealth Provider Manual

MassHealth Provider Manuals are available on the Web at www.mass.gov/masshealth from the Provider Library.

- Subchapters 1 – 3 are the administrative and billing regulations
- Subchapter 4 is the Independent Nurse Program regulations
- Subchapter 5 is the Administrative and billing instructions and error codes and explanations
- Subchapter 6 is the service codes
- Appendix A is the Directory

There is also a link to the Massachusetts Division of Health Care Finance and Policy (DHCFP) for rate information.

MassHealth Card



Please be sure to use the Member ID Number (RID) when billing. Do not use the Card Number.

Electronic Funds Transfer

Electronic Funds Transfer (EFT) offers direct deposit of your payments. Benefits include:

- Payments are deposited into your account every Monday
- Reduces problems due to lost, stolen or misdirected checks
- No more undeliverable mail

To apply, download the forms from mass.gov/masshealth and mail to:

- MassHealth
- Attn: Provider Enrollment
- P.O. Box 9118
- Hingham, MA 02043
- Or fax: 617-988-8974

Provider File Integrity

- Any change in your relationship with MassHealth must be communicated immediately to Provider Enrollment and Credentialing to maintain accurate information on your provider file.
- All updates must be submitted in writing to:

  MassHealth

  Attn: Provider Enrollment and Credentialing

  PO Box 9118

  Hingham, MA 02043

  or faxed to 617-988-8974
- Include your MassHealth provider number on all correspondence
- Keep all information accurate, to include:
  - Addresses: legal entity, doing business as, check and remittance and informational mailing
  - Telephone numbers
  - Licensure and certifications

Prior Authorization

Per subchapter 4 (414.412 (A) (1), prior authorization must be obtained from MassHealth as a prerequisite to payment for all nursing services. Prior authorization must be obtained from MassHealth before services are provided to the member. Without such prior authorization, services will not be reimbursed by MassHealth.

When a PA is near expiration, a new request for a PA should be submitted at least 14 days prior to the expiration date of the existing PA to ensure time for processing. PAs submitted after the expiration date of the will not be dated retroactively. PAs received after expiration will be modified to the date of receipt of the new PA request. And finally, the Independent Nurse cannot begin working until they have an approved PA.

Prior Authorization

PA requests for members over 22 years will be processed by the MassHealth PA unit. Requests should be submitted via APAS at www.masshealth-apas.com. To gain access or receive training on APAS call 866-378-3789. For questions regarding the PA call 617-451-7176.

PA requests for members under 22 years will be processed by the Community Case Managers (CCM). The CCM works to ensure that members are provided with a coordinated service package that meets the members individual needs and to ensure that MassHealth pays for services that are medically necessary. CCM may be contacted at 800-863-6068

Prior Authorization

Prior Authorization Tips:

- You may submit your prior authorization request through APAS, www.masshealth-apas.com or 866-378-3789
- Services must be ordered by the physician (130CMR 414.408 (B) (1)
- For members over the age of 22, a Request and Justification for Continuous Skilled Nursing Services form (RNJ) must be submitted with the PA request
- If you do not use APAS or CCM, you must submit a paper PA form to:

  MassHealth

  Attn: PA Unit

  600 Washington Street

  Boston, MA 02110

PCC Referral Numbers

PCC referral numbers have 7 digits

The first characters of the referral number indicates the provider type:

- Group: 97
- Out Patient Department (OPD): 12
- Nurse Practitioner: 03
- Community Health Center: 13
- Individual: 01, 201, 301, 31, 61

If the client has a PCC, the number must be listed in field 7 of claim form 9. REVS will confirm the PCC name and phone number. Contact the PCC for the referral number.

Independent Nurse Billing Tips

Please refer to the handout Independent Nurse Billing Tips for details.

- Hours must be billed based on calendar day, not shift
- Overtime hour calculations – see regulation 414.416
- Service codes – see Subchapter 6
- Multiple - Patient Nursing Services – see DHCFP regulations 50.04(2)
- Faxing Paper Claims – must be faxed by Monday noon to 781-741-3028
- Holidays – see DHCFP regulations 50.02
- Description of Hourly Nursing – see DHCFP regulations 50.02
- Billing across State Fiscal Years (June 30th to July 1st)

Paper Claim Billing

Required fields:

Field #	Field Name	Required Optional	Description
1	Provider's Name, Address & Telephone Number	R	Enter your name, address and telephone number
2	Pay To Provider No.	R	Enter your seven (7) digit MassHealth Provider Number
4	Prior Authorization No.	R	Enter the six (6) digit prior authorization number assigned for the dates of service being billed
7	Referring Provider's Name	O	If applicable, enter the referring provider's name
8	Referring Provider's No.	O	If applicable, enter the referring provider's number (PCC #)
9	Member's Name	R	Enter the members name
10	Member ID No.	R	Enter the ten (10) digit MassHealth member ID number. Do not use the card number.
11	Date of Birth	R	Enter the member's date of birth MMDDYY
12	Sex	R	Enter the member's gender
14	Patient Account No.	O	If you see more than one client, this field can be important to identify the claim in case of an error.
15	Place Of Service	R	Enter 02.

Paper Claim Billing

Required fields:

Field #	Field Name	Required Optional	Description
16A	Is Member Being Treated As A Result Of An Accident?	R	Check the appropriate box.
16B	If Yes, Type &	O	If 16A is yes, this field is required. Refer to Subchapter 5 for the applicable codes
16C	Date of Accident	O	If 16A is yes, enter the date of the accident
26	Date Of Service	R	Enter the date of service. If it is only a single date, you may enter only the From date. If it is a span date, you must enter From and To dates.
27	Description Of Service	R	Enter either “Nursing Services” or the description of the procedure code.
28	Procedure Code-Modifier	R	Enter the appropriate procedure code. If applicable, enter the appropriate modifier as well.
31	Units Of Service	R	Enter the appropriate number of units for the service date. Each unit represents 15 minutes, so one hour equals 4 units.
32	Usual Fee	R	Enter the appropriate dollar amount for the units billed. This should be the unit rate times the number of units.

Paper Claim Billing

Required fields:

Field #	Field Name	Required Optional	Description
38	Authorized Signature	R	Sign the claim
39	Billing Date	R	Enter the date you signed the claim. This date cannot be prior to last date of service listed above in field 26.
40	Adjustment/Resubmittal	O	If the claim is an adjustment or resubmittal, check the appropriate box. Only use the resubmittal option for certain claims over 90 days.
41	Former Transaction Control No.	O	If the claim is an adjustment enter the TCN of the paid claim that you are adjusting. If the claim is a resubmittal, enter the TCN of the earliest denied claim, when required. This field is required if either of the boxes in field 40 are checked.

What Is A Remittance Advice (RA)?

- A report that provides claims processing status to providers indicating if the claim status is paid, denied or suspended
- The RA is utilized by providers in order to reconcile their account with MassHealth
- Available on paper or electronically
- Used as a supplement to the 835 transaction
- The paper RA also provides message text and financial information

What Is A Remittance Advice (RA)?

Claims will appear on remittance advice in approximately 10 days

- Providers can access their remittance advice (835) through www.mass.gov/masshealth
- Reference the Remittance Advice Message Text for updates and information pertaining to claims processing, rate changes and policy
- Message text can be accessed through the Provider Library located on ww.mass.gov/masshealth

Message Text Example

(09) MEDICAL SERVICE (9) REMITTANCE ADVICE RUN: 1900 03/14/06
COMMONWEALTH OF MASSACHUSETTS PROVIDER NUMBER 0701234
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES PROVIDER PAGE 1 REPORT PAGE 31000
OFFICE OF MEDICAID

JANE DOE

100 MAIN STREET
BOSTON MA 02110

GENERAL TOPICS ALL PROVIDERS

INCREASED DATE OF SERVICE FOR CHECKING MEMBER ELIGIBILITY

EFFECTIVE SEPTEMBER 1, 2005, MEMBER ELIGIBILITY CAN BE VERIFIED FOR ANY DATE OF SERVICE WITHIN THE PAST 13 MONTHS RATHER THAN ONLY THE PREVIOUS SIX MONTHS. THIS CHANGE WAS IMPLEMENTED FOR THE FOLLOWING VERIFICATION METHODS: WEBREVS, REVSPC SOFTWARE, AUTOMATED VOICE RESPONSE (AVR) SYSTEM, THE ELIGIBILITY OPERATOR, AND THROUGH THIRD PARTY VENDORS SUCH AS NEHEN. PLEASE NOTE THAT ELIGIBILITY VERIFICATION VIA THE MASSHEALTH POINT OF SERVICE (POS) DEVICE IS STILL LIMITED TO SIX MONTHS. IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE REVS HELPDESK AT 1.800.462.7738 AND SELECT OPTION 2, THEN OPTION 5. UPDATES ABOUT THIS SYSTEM ENCHANCEMENT WILL BE POSTED ON WWW.MASSREVS.EDS.COM.

Remittance Advice Header

The following would be reflected on all RA's

- Provider Name, Number and Address
- RA Number, Run Number and Paid Date
- Patient Account Number
  - Assigned by provider
- Recipient Name
- Recipient and MassHealth Number (RID)
- Transaction Control Number (TCN)
  - Ten-digit number that is a unique identifier generated at the time of scanning that follows claim throughout the processing cycle
- From and To dates
- Servicing Provider Number
- Procedure code/modifier
- Place of service
- Units

Remittance Advice Header

- Amount Request
  - Actual amount billed for services
- Other Paid Amount
  - Any other payment from another insurance as listed on the claim form
- Amount Paid by Medicaid
  - Actual payment made to the provider
- Status
  - Paid, Suspended, or Denied
- Remarks
  - Indicates Tape or Paper submission / original or resubmission
- Errors
  - If applicable, indicates the error in submission. Error codes maybe found on the Web in the provider manual, Subchapter 5, Part 6

Remittance Advice Example

```
(09)                                    MEDICAL SERVICE (9) REMITTANCE ADVICE                        RUN: 1900 03/14/06
JANE DOE                                    COMMONWEALTH OF MASSACHUSETTS                        PROVIDER NUMBER 0701234
                                  EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES          PROVIDER PAGE     REPORT PAGE
                                              OFFICE OF MEDICAID                               1           31000
100 MAIN STREET
BOSTON, MA 02110


PATIENT    RECIPIENT RECIPIENT    TCN       FROM    TO   SERV-   PROC   PLACE  UNITS AMOUNT  OTHER    AMOUNT   STATUS   REMARKS
ACCOUNT    NAME      ID                     DATE   DATE  ICING   CODE/    OF         REQUEST PAID     PAID BY
NUMBER                                                   PROV NO     MOD SERV              AMOUNT   MEDICAID
1234567890  SMITH    012345678  600110001A 070105 070105 0701234 T1002 UJ  02  100     96900       00    96900 PAID     (ORIG)
   DIAG       PA AB1234  OTH INS             ERRORS
1234567890  SMITH    012345678  600110002A 070105 070105 0701234 T1002 UJ  02  100     96900       00          DENIED   (ORIG)
   DIAG       PA AB1234  OTH INS             ERRORS 777
1234567890  SMITH    012345678  600110003A 070105 070105 0701234 T1002 UJ  02  100     96900       00          SUSPENED (ORIG)
   DIAG       PA AB1234  OTH INS             ERRORS 061
```

Transaction Control Number

The **TCN** is assigned to each claim line adjudicated by MassHealth and appears on the remittance advice. Once a TCN is assigned it remains with the claim indefinitely.

- Allows the provider to track claims
- Used to reference original claims during claim adjustments and, in certain circumstances, during claim resubmittals

5 005 217 38 A

- Character 1 = century (2005)
- Characters 2 – 4 = Julian day of the calendar year (005 is January 5)
- Characters 5 – 7 = batch number (in electronic claims character 5 is an alpha)
- Characters 8 – 9 = sequence number in batch
- Character 10 = claim detail line letter number (A = 1, B = 2, etc)

Corrective Action for Claims

Denied

- Verify the error code, make any necessary corrections and re-bill
- If a denied claim is billed over 90 days from the date of service and you are changing the service date or procedure code, you must submit the appropriate documentation with your claim. You may only submit one claim line per form and must check field 40, the resumittal box at the bottom of the claim form and enter the original, denied TCN in field 41.

Suspended

- You are not required to take any action. The suspended claim will appear on a subsequent RA as “Paid” or “Denied”
- A suspended claim is in process and should never be re-billed while in process
- Most common is claim needs to be manually reviewed by MassHealth
  - For appropriate fee determination
  - Medical necessity of service
  - Review of an attachment
  - To allow time for member eligibility and other files to be updated

Corrective Action for Claims

Incorrectly Paid

- Follow the *Adjustment* Procedure:
  - Submit one claim line per claim form
  - Make all necessary corrections
  - Check the adjustment box at the bottom of the new claim form
  - Enter the most recent “Paid” TCN in the Former TCN box of the new claim form
  - Electronic claims may be adjusted and resent electronically by voiding and replacing the original claim

Over Payment

- Should request a *void*.
  - Circle the claim line to be voided on a photocopy of the RA
  - Send the photocopy and a signed letter authorizing the void
  - If you submit electronically, you may also submit your voids electronically

Top Errors To Avoid When Billing

Error Code	Description	Resolution
038	Invalid place of service	The place of service code is either missing or invalid. Independent Nurse providers should use 02 for paper claims and 12 for electronic claims.
103	Duplicate claim	The procedure entered on the claim is not the procedure code listed under the prior authorization number entered on the claim.
256	Procedure not on prior authorization	The procedure code you are billing is not listed on the prior authorization, or the incorrect prior authorization was listed.
178	Provider type/Procedure conflict	Only use the codes listed in your manual in Subchapter 6.
770	Max units exceeded	Call MassHealth Customer Service for amount of units for procedure code.
777	Service date after PA expired	Service date must be prior to the expiration date of the PA. Verify the correct PA was used.
778	Prior authorization number not on file	Enter the correct PA number on the claim.
911	Prior Authorization partially exhausted	You must bill only the number of units left on the PA.

Contact Information

The contact information:

MassHealth Customer Service – 800-841-2900

Keith West - 800-841-2900, option 1, option 6, extension 2985

Claim fax - 781-741-3028

CCM – 800-863-6068

MassHealth PA Unit – 617-451-7176

APAS – 866-378-3789

REVS – 800-462-7738

PCSS support - 800-841-2900, option 1, option 4